SOUTHWEST WASHINGTON MEDICAL CENTER

POLICY ④ PROCEDURE

Number: 8610.F002

Title: Patient Financial Policy

Originating Department: Administration

RECEIVED
DEC 20 2006
DEPARTMENT OF HEALTH
Center for Health Statistics

Effective: 07/87
Revised: 12/18/06
Reviewed:
Approved by: **Page: 1 of 8**

GENERAL POLICY STATEMENT:

Southwest Washington Medical Center shall use standard practices for the collection of receivables and the administration of charity allowances. Emergent and/or urgent services are provided regardless of the patient's ability or willingness to pay.

PURPOSE:

To provide a fair and effective patient financial policy which supports the Medical Center's goal of providing high-quality medical services at a reasonable cost to the community, and to govern the provision of indigence (charity) allowances for services provided by all Southwest Washington Medical Center departments/entities.

DEFINITIONS:

Indigent Persons: Patients who have exhausted all third-party sources, including Medicare and Medicaid, and whose gross income is below 400% of the Federal Poverty Guidelines, adjusted for family size.

Charity Care: Appropriate hospital-based medical services provided to indigent persons.

Bad Debt: Uncollectible amounts, excluding contractual adjustments, arising from failure to pay, by patients whose care is not classified as charity care.

Appropriate Hospital-based Medical Services: Hospital services performed to diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life; cause suffering or pain; result in illness or infirmity; threaten to cause or aggravate a handicap; or cause physical deformity or malfunction, with no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting the service. Course of treatment may include observation only, or when appropriate, no treatment at all.

Responsible Party: The individual responsible for the payment of all hospital charges not subject to third-party sponsorship.

Income: Total cash receipts before taxes derived from wages and salaries, welfare payments, Social Security payments, strike benefits, unemployment or disability benefits, child support, alimony, and net earnings from business and investment activities paid to members of the household.

Family: A group of two or more persons related by birth, marriage, or adoption who live together, including children when they are claimed as dependents on the most recently filed tax return. Family size may also include domestic partners when their income is included in household income.

Initial Determination of Sponsorship Status: An indication, pending verification, that services provided by the hospital may or may not be covered by third-party sponsorship, or an indication from the responsible party, pending verification, that he/she may meet criteria for designation as an indigent person, qualifying for charity care.

Final Determination of Sponsorship Status: The verification or lack of third-party coverage as evidenced by payment received from the third-party sponsor, or denial of payment by the alleged third-party sponsor, with verification of the responsible party's qualification for classification as an indigent person following the completion of any appeals, the responsible party may be entitled to submit and which on their merits have a reasonable chance of achieving third-party sponsorship in full or in part.

Third-party Coverage and Third-party Sponsorship: An obligation on the part of an insurance company or governmental program contracting with hospitals or patients, to pay for the care of covered patients and services, which may include settlements, judgments, or awards received and related to the negligent acts of others resulting in the medical condition for which the patient has received hospital services.

Emergency care or Emergency Service: Services provided for care related to an emergency medical or mental condition.

Emergency Medical Condition: A medical condition, including severe pain, manifesting itself by acute symptoms of sufficient severity the absence of immediate medical attention could reasonably be expected to result in: Placing the health of the individual (for pregnant women, the health of the woman or her unborn child) in serious jeopardy; Serious impairment of bodily functions; Serious dysfunction of any bodily organ or part.

CREDIT/COLLECTION PROCEDURES

A. ***Scheduled Services***

1. Pre-Admission.
   a. Patient Access/Registration shall pre-admit patients to assist them in obtaining the full benefit payable from their third party payor
   b. Referrals to the Financial Counselors shall be made for patients without adequate insurance or the ability to pay.
   c.. Accounts referred to the Financial Counselors will be evaluated to determine the availability of additional coverage, such as COBRA, TPL (Third Party Liability), or Medicaid, and will assist patients in pursuing eligibility
2. Financial arrangements
   a. Pre-payments
      1) Pre-payment may be required for uninsured or underinsured scheduled patients
      2) Deposits and/or interim payments may be requested for extended stay or

high cost hospital services

b. Credit
   1) Credit may be extended to patients with a minimum of 80% insurance coverage with satisfactory payment history when they assign their benefits to the Medical Center and agree to a payment plan as listed in the Payment Plan Options section (Section D)
   2) Credit will not be extended to patients that do not assign their benefits to SWMC, patients with unsatisfactory payment history, or for patients with third party coverage that does not honor the patient's assignment of benefits to the Medical Center. These patients will be classified as private pay and will be subject to pre-payment of anticipated charges
   3) Credit will not be extended for elective and/or cosmetic procedures

3. Referral to DSHS (Medicaid)
   a. Referrals to the Department of Social and Health Services shall be made by the Financial Counselors for patients without adequate insurance or the ability to pay
   b. A screening tool/questionnaire will be used to determine whether a patient should be referred to Medicaid for potential eligibility/coverage.

4. Co-payments/Co-insurance
   a. Co-pays under managed care contracts are due in full at the time of service
   b. Large coinsurance amounts may be subject to pre-payment requirements; credit may be extended if patient has a minimum of 80% coverage, agrees to a payment plan as listed in the Payment Plan section (Section D), and if the patient has a satisfactory payment history

B. ***Unscheduled Services***
1. Admission/Registration
   a. Patient Access/Registration shall assess the availability of third party coverage and notify third party payors as necessary to assist patients in obtaining the full benefit payable under their policy

2. Financial Arrangements
   a.. Patient Financial staff assists patients in developing a payment plan for their portion of the estimated cost of services.
   b. Deposits and/or interim payments may be requested for extended stay or high cost hospital services
   c. For patients without adequate insurance or the ability to pay for their services, Patient Financial staff shall screen for potential Medicaid coverage and assist with the completion and delivery of applications to the local Medicaid office
      1) Referrals to the Department of Social and Health Services shall be made for patients without adequate insurance or the ability to pay if it appears they may be eligible for benefits
      2) A screening tool/questionnaire will be used to determine whether a patient should be referred to Medicaid for potential eligibility/coverage

3. Co-payments/Co-insurance
   a. Co-pays under managed care contracts are due at the time of service
   b. Credit may be granted for coinsurance amounts subject to payment plan provisions (Section D)

C. ***Third party billing***

1. The Medical Center is unable to await payment/settlement of third party liability or disputed claims.
2. Patients are responsible for immediate payment in full when insurance has not paid within 60 days of billing
3. Immediate payment in full is due from the patient upon notification that the claim has been denied by the payor due to lack of response from the patient or when a patient refuses to sign subrogation paperwork
3. Immediate payment in full is due from the patient upon notification that the third party payor does not or has not honored the Medical Center's assignment of benefits, or when the patient has been paid by a third party payor for the services provided by the Medical Center

D. ***Payment Plan options include:***

1. Payment on an interim basis for long-stay patients with payment of the balance by discharge or upon presentation of the final bill using cash, check, or credit card
2. Payment in full at discharge or upon presentation of the final bill by cash, check, or accepted credit card
3. Monthly payments consistent with Medical Center policy
   a. For initial balances less than $250, the minimum payment is $35
   b. For initial balances greater than $250, the minimum payment is 12%
4. Contract financing when available and the patient meets contract financing criteria

E. ***Contract Financing***

1. The Medical Center may enter into agreements from time to time with lending institutions to provide contract financing services to patients needing lower monthly payments or a longer payment term than described in the Payment Plan section (Section D)
2. Patients are encouraged to use these services when available and appropriate
3. General eligibility criteria:
   a. Employed or steady income
   b. Apparent ability to make the contracted payment
   c. Meeting criteria established by the lending institution regarding the size of the monthly payment and the length of the payment plan

F. ***Prompt Pay Discount***

1. Prompt pay discounts may be offered for payment in full as long as the payment is received within 10 days of the request for discount
2. Accounts that have been assigned to collection do not qualify for a prompt pay discount.

G. ***Charity***

1. Requests for charity shall be submitted to the Patient Financial Services office for determination of the benefits available under SWMC charity care criteria
2. When a completed charity application is filed with all required documents, collection efforts shall be postponed until a decision is reached regarding approval, partial

approval, or denial of the application

INDIGENCE/CHARITY PROCEDURES

A. Emergent and/or urgent services
   1. Emergent and/or urgent services are provided regardless of the patient's ability or willingness to pay

B. The Patient Financial Services Department has sole responsibility for determining indigence eligibility
   1. Indigent residents of our service area are eligible to receive medically-necessary emergent and/or urgent healthcare at reduced or no charge
      a. Patients shall be eligible to apply for uncompensated care services when their gross family income is below 400% of the Federal Poverty Guidelines
      b. Indigence allowances are not provided for elective services
   2. Indigence allowances shall not be provided for amounts subject to third-party sponsorship
      a. To qualify for services at reduced charge, third-party sources of payment such as Medicare, Medicaid, insurance, or other third-party responsibility or liability must be utilized
      b. SWMC actively refers patients to the Department of Social and Health Services (DSHS) and assists patients in completing applications for benefits which may be available to them under Medicaid rules and regulations
   3. Patients do not qualify for charity if the third party (insurance) payor denies the claim based on lack of cooperation, lack of response to information requests, or refusal to sign subrogation agreements
   4. Patients do not qualify for charity if Medicaid denies their application based on the timeliness of their application, or for failing to provide complete information that would allow DSHS to determine eligibility for coverage
   5. Non-resident patients staying in the United States under the sponsorship of a United States resident are eligible for consideration under this policy, provided the combined income of the patient and sponsor meets charity allowance criteria
   6. Non-resident aliens do not qualify for charity if they refuse to provide information required for the Medical Center to apply for funding under Section 1011 of the Medicare Modernization Act (Funding of Emergency Services to Undocumented Aliens)
   7. A sliding scale shall be used to determine the amount written off to indigence (charity) allowance

Percent of Poverty	Charity %	Patient %
000-200%	100%	0%
201-225%	80%	20%
226-250%	70%	30%
251-275%	60%	40%
276-300%	50%	50%
301-325%	40%	60%
326-350%	30%	70%
351-375%	20%	80%
376-400%	10%	90%
401+%	0%	100%

a. For clinic visits, the sliding fee schedule shall be applied to charges in excess of a $10 patient co-payment
b. Patient balances remaining after the application of the sliding fee schedule are payable utilizing the options listed in the Payment Plan Options section of this policy (Section D)

8. Applications are available in the Patient Registration and Patient Financial Services offices
   a. For consideration, a completed application must be made by the patient or guarantor of the account
   b. Documentation to validate income, such as W-2 withholding statements, pay stubs, income tax returns from the most recently-filed calendar year, profit and loss statements for self-employed individuals, child support, forms approving or denying eligibility for Medicaid and/or state-funded medical assistance, forms approving or denying unemployment compensation, written statements from employers or welfare agencies, or statements from patients documenting income must be supplied within 14 calendar days of the submission of a request for services at less than full charge (indigence/charity application)
   c. Income for parents of adult patients that are temporarily living with their parents does not need to be included on the charity application unless a dependency is indicated on the most recent tax return
   d. A DSHS (Medicaid) denial or completion of the Medicaid eligibility screening questionnaire showing the patient does not meet criteria for DSHS coverage may be required
      1) Proof of subsequent Medicaid coverage may be used in lieu of a charity application upon approval of a Patient Financial Services manager.
      2) The above information and documentation may be used to establish accuracy and completeness of the information and shall be filed with the application
      3) Approval or denial shall be made in writing within 14 calendar days of receiving the documentation.
      4) Requests for services at reduced or no charge shall be evaluated for compliance with this policy by Patient Financial Services staff
      5) Completed applications meeting criteria shall be routed with supporting documentation to a Patient Financial Services manager for review and approval

C. Right of Appeal
1. Responsible parties with incomes below 400% of the Federal Poverty Guidelines are entitled to appeal their denial
   a. Appeals must be in writing and mailed to the Director of Business Services, P. O. Box 1588, Vancouver, Washington, 98668-1588
   b. For an appeal to be considered, it must be postmarked no later than 30 calendar days following the date of the initial denial
   c. Accounts shall not generally be assigned to an outside collection agency during this 30-day period

2. Appeals shall be reviewed by the Chief Financial Officer or equivalent
   a. The responsible party shall be notified of the outcome of the appeal within 14

calendar days

1) When the denial is upheld, a copy of the denial shall be sent to the Department of Health within 14 calendar days

3. When there is a change of circumstances and the account has not been assigned to a collection agency, an application previously denied may be reconsidered upon receipt of a properly completed application

D. Exceptions

1. SWMC reserves the right to grant additional charity requests, at its sole discretion, in situations falling outside these guidelines

ADMINISTRATIVE PROCEDURES

A. ***Contractual Allowances***

1. Contractual allowances for government-directed programs such as Medicare, Medicaid, Tricare and industrial coverage shall be adjusted as required by the Medical Center's participation agreements
2. Managed Care discounts shall not be given without a copy of the contract on file authorizing the specific discount as a contractual obligation

B. ***Refunds***

1. Refund requests shall be prepared by the Patient Financial Services staff
2. Refunds of up to $5,000 shall be approved by a Patient Financial Services manager when the refund request is accompanied by documentation supporting the refund.
3. Refunds over $5,000 shall be reviewed by the Director of Business Services.

C. ***Write-offs***

1. Bad Debt/Uncollectible Account
   a. Accounts shall be considered for bad debt write-off when the patient has demonstrated an unwillingness to pay according to SWMC's payment policy
   b. Telephone calls and written communication shall be used to facilitate payment
   c. Accounts shall be referred to a collection agency when the patient has not agreed to an acceptable payment plan, does not respond to telephone calls and/or letters, or cannot be located
   d. Unpaid accounts shall be sent to a collection agency except for bankruptcies, small balances, and accounts meeting charity criteria
2. Contractual allowances
   a. As prescribed by regulation or contract
3. Charity
   a. As prescribed by the process described above

D. ***Medicare Bad Debt vs. Charity***

1. Outstanding balances of patients owing Medicare deductibles and/or co-insurance shall be written off to Medicare Bad Debts rather than charity, providing an application is received and indigence is established under the financial guidelines of the charity program
2. Separate charge-off codes and general ledger accounts shall be maintained

E. ***Write-off Approval Process***

1. Adjustments will be input on a daily basis
2. Adjustment batches will be reviewed by a Patient Financial Services manager
3. The list of accounts assigned to collection will be reviewed by a Patient Financial Services manager
4. Account write-offs greater than $5,000 shall be reviewed by the Director of Business Services
5. Summary of the bad debt and charity write-offs will be provided on a monthly basis to the Chief Financial Officer

F. ***Exceptions to Policy***

The Director of Business Services is authorized to make exceptions to policy when an exception serves the interest of the Medical Center